California Department of Health Services
Public Health Bioterrorism Response and Preparedness Activities
Summary

Introduction

In response to the heightened threat of bioterrorism, Congress authorized funding through the Public Health and Social Services Emergency Fund (Section 319 of the Public Health Services Act, 42 U.S.C. 247 d) to support countering potential biological threats to the civilian population. This funding is provided under the Department of Defense and Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, 2002 (Public Law 107-117). Beginning in 2002, more than $100 million in federal funding became available to governmental agencies and municipalities in California via three funding award mechanisms:

(1) Cooperative Agreements with the California Department of Health Services (CDHS) and with Los Angeles County, awarded by the Centers for Disease Control and Prevention (CDC), for bioterrorism and public health emergencies.

(2) Cooperative Agreements with CDHS and with Los Angeles County, awarded by the Health Resources and Services Administration (HRSA) for hospital planning and preparedness.

(3) Contracts with seven (7) California cities for metropolitan emergency bioterrorism preparedness for regional preparedness planning as part of the Metropolitan Medical Response System (MMRS) Initiative.

The cooperative agreements are being awarded on a non-competitive basis, with 20 percent of each award available for immediate expenditure, with up to half of the initial award available for planning, development of an implementation plan, and addressing critical benchmarks (see Attachment A). CDC and HRSA will release the remaining 80 percent upon receipt, review, and approval of California's implementation plans (see Attachment B for a funding summary).

State Goals

Over the next five years, in addition to response planning and coordination, the State's overall bioterrorism preparedness goals are to: (1) strengthen the public health system infrastructure capacity, including laboratory and surveillance capacity, needed to accurately and rapidly detect, control and prevent illness and injury resulting from biological terrorism and infectious disease outbreaks; (2) develop a seamless response to potential acts of bioterrorism that includes public health, medical care, and emergency/disaster management systems (See Attachment C); and (3) ensure that rapid and secure communication exists among public health and public-private sectors during an event. Each of these interconnected goals must be met, with functions able to move smoothly and quickly in well-practiced ways, to address bioterrorist threats to California communities.

CDC Public Health Preparedness and Response to Bioterrorism Program

The Public Health Preparedness and Response to Bioterrorism Program, administered by CDC, will issue supplemental awards to State and Territorial health departments and selected municipal governments. The funding -- $60.8 million to CDHS and an additional $24.59 million to Los Angeles County -- is issued in two phases, with a budget period ending on August 30, 2003.

Purpose: To upgrade California's state and local public health jurisdictions' preparedness for and response to bioterrorism in six (6) areas: Planning and Readiness Assessment; Surveillance and Epidemiology Capacity; Biologic Laboratory Capacity; Communications and Information Technology; Health Risk Communications and Information Dissemination; and Education and Training.

Implementation Requirements: Twenty percent of California's and Los Angeles' allocation -- $12,163,249 and $4,918,234 -- were made available for immediate use. Up to half of these amounts can be used for development of the workplan addressing 14 critical benchmarks required to obtain the remaining 80 percent of funds. The remainder of the initial award can be used to support development and implementation of the critical benchmarks and to cover urgent costs associated with bioterrorism response efforts incurred after September 11th, 2001, including those costs incurred by local health jurisdictions. Funds in the amount of $48,652,996 for CDHS and $19,672,937 for Los Angeles County are restricted pending the receipt and approval of the work plan (estimated to be on or around May 15, 2002), and are to be used to carry out workplan activities in the six focus areas.

California's Work Plan & Approach: A condition of the application required documentation of meaningful collaboration between CDHS and local public health officials in all aspects of the grant, including resource allocation. During the planning period, CDHS convened focus groups with DHS leads and co-leads-representatives from the California Conference of Local Health Officers (CCLHO) and the County Health Executives Association of California, to respond to the requirements of the cooperative agreement. A consensus process sought to balance the needs of state and local public health departments, and was guided by the knowledge that resources should be directed as close to the location of need/response as possible. Of the $60.8 million available to CDHS, $41.9 million is earmarked for direct funding/local benefit to local health jurisdictions. A work plan was submitted by CDHS on April 15, 2002 for the activities described below. The project period for these activities is February 19, 2002 through August 30, 2003.

Focus Area A: Preparedness Planning and Readiness Assessment

This CDC Focus Area requires that CDHS establish strategic leadership, direction, assessment, and coordination of activities (including the National Pharmaceutical Stockpile response) to ensure statewide readiness, interagency collaboration, local and regional preparedness for bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. Of the $19.9 million available in this area, CDHS proposes to expend $3.28 million for specific activities (below) and to support 15 limited-term staff.

- Support the activities of the Office of Executive Director (Dr. Richard Burton) to lead inter-governmental planning and response activities within CDHS.
- Convene a Working Group of the Subcommittee on the Protection of Public Health to advise CDHS on inter-governmental, public-private linkages and on capacity development and ongoing assessments of need.
- Expand the planning and assessment activities of CDHS' Emergency Preparedness Office to develop an integrated assessment of emergency preparedness and response capabilities for state/local purposes and for assessment of public health emergency statutes, complete smallpox, vaccination guidelines, and vaccine management guidelines for influenza, smallpox, and anthrax, and laboratory reporting planning, and continue work on the state-level aspects of the Interim National Pharmaceutical Stockpile plan.

- Complete and augment existing state planning documents with strong public health perspectives and initiate regional plans, including exercising those plans.
- Coordinate and integrate planning and assessment with hospitals and emergency medical service providers at the state level.
- Expand the training functions to the Emergency Preparedness Office to include one statewide conference to showcase "best practice" activities, one Public Health Grand Rounds teleconference, and training in vaccine administration, contraindications, adverse reactions surveillance (smallpox) and handling of needles. CDHS will contract with the California Specialized Training Institute or other entities for expanded training on standardized emergency management, incident command systems, emergency operations management, field response protocols, and bioterrorism plan implementation.
- Purchase equipment to complete the CDHS Departmental Operations Center and the Joint Emergency Operations Center.
- Establish a system for monitoring progress, allocating resources, and developing work plans with local partners, state agencies, and contractors.

Of the $19.9 million available in Focus Area A for planning and readiness activities, $16.6 million is available to local health jurisdictions. This figure includes the $7.5 million appropriated via expedited standard agreements to local health jurisdictions to cover their costs of post-September 11, 2001 recovery, immediate planning, and urgent needs. The remaining $9.1 million can by used by local health jurisdictions to establish local leadership, designate staff in charge of planning, establish local advisory committees, assess local capacity, and prepare a local bioterrorism preparedness and response plan, including 24/7 notification, activation, and testing annually of an emergency response system, and local training and risk communication needs.

Focus Area B: Surveillance and Epidemiology Capacity

This CDC Focus Area requires that the State and local health departments have resources to enhance, design, or develop systems for rapid detection of unusual outbreaks of illness that may be the result of bioterrorism, other outbreaks of infectious diseases and other public health threats and emergencies. Funds are also dedicated to assisting the state and local health departments to establish expanded epidemiologic capacity to investigate and mitigate outbreaks of illness. Of the $12.56 million available in this area, CDHS proposes to expend approximately $4.0 million for specific activities (below) and to support 26 limited-term staff.

- Expand comprehensive statewide surveillance for priority threat agents and ongoing surveillance of all other reportable diseases.
- Develop and implement new training on bioterrorism recognition and response and in epidemiologic outbreak investigation.
- Expand influenza surveillance to include additional Kaiser Permanente hospital sites and to include automated data processing, interpretive analyses, and epidemiologic response protocols.
- Continue funding for the California Electronic Laboratory Alert and Reporting project to complete a feasibility study and expand from a pilot to a statewide production system.
- Expand the National Electronic Disease Surveillance System as identified in California's Five-Year NEDSS Strategic Plan.
- Expand surveillance activities within the CDHS Office of Binational Border Health for recognition and reporting of diseases and syndromes that may represent bioterrorism.
- Expand rash surveillance system to include vesicular rash illnesses.

- Examine and assess new databases for use in surveillance (e.g., medical examiners/coroners, emergency responders, poison control centers, 911 systems, pharmacies, veterinarians).
- Expand field epidemiologic response capacity related to occupational settings via development of investigation and training protocols.
- Expand linkages with veterinary laboratories to improve surveillance of zoonotic diseases.
- Develop threat assessment tools for food security.
- Develop risk and vulnerability assessments/security guidelines for public water systems.
- Provide technical support for new and existing local surveillance projects.

Of the $12.56 million available in this Focus Area for surveillance and epidemiology, $8.5 million is available for local health jurisdictions. These funds may be used strengthen local health jurisdictions' ability to receive and evaluate disease reports on a 24/7 basis, conduct epidemiologic investigations, determine appropriate interventions, and judge whether a situation is suspicious for bioterrorism. Funds can also be used to enhance outreach to health care providers in support of appropriate disease reporting and recognition of clinical manifestations of diseases that may be a result of bioterrorism. A portion of the funds could be used for local novel, active or sentinel surveillance systems and infrastructure.

Focus Area C: Laboratory Capacity for Biologic Agents

This CDC Focus Area requires CDHS to ensure that core diagnostic capabilities for bioterrorist agents are available at the state public health laboratories, and that a coordinated laboratory response plan is in place. These funds will enable the State to develop the capability and capacity to conduct rapid and accurate diagnostic and reference testing for select biologic agents likely to be used in a bioterrorist attack. Of the $8.6 million requested for this area, $3.8 million will cover the cost of activities (below) and 17 limited-term staff.

- Augment the State laboratories capacity to meet CDC laboratory requirements for Level C and B labs -- add staff to the Deputy Director of Laboratory Science, Local Laboratory Assistance/Quality Assurance Reporting Section, Food, Drug and Radiation Safety Division, and the Viral and Rickettsial and Microbial Diseases Laboratories (the Molecular Diagnostic, Environmental Microbiology, and Water/Shellfish, Special Pathogens, Enterics, and Serology Units).
- Oversee the development of 5-7 new Level B public health laboratories.
- Conduct/complete a statewide assessment of the completeness of LRN guidelines, assess LRN B laboratories' illness and injury prevention programs; survey LRN A, B, and C laboratories to determine if QA/QC procedures are being followed.
- Work with CDC to devise external proficiency testing protocols that are consistent with select agent rules.
- Provide training and exercises to reinforce proper triage procedures and secure storage of critical agents.
- Develop purchasing and inter-laboratory supply sharing methods.
- Convene a joint state-local planning committee to prepare a comprehensive plan to address the training needs of level A laboratories, including training positions in Level B laboratories.
- Identify a CDHS Laboratory Training Coordinator to develop Level A laboratory training resources.
- Develop an integrated state laboratory response plan for bioterrorism.
- Establish operational protocols for laboratory support, including environmental and chain-of custody procedures.

- Develop a protocol for tracking and safe handling, packaging and transport of human blood and urine to a laboratory for chemical agent testing.
- Provide technical assistance and oversight to the local Level A Public Health Surge Support and Training Grant Program.

Of the $8.6 million available for this capacity, $4.7 million is available in contract funds to support local public health laboratory capacity. Of that amount, $2.245 million is available for Local Level B Laboratory lab support for 5 laboratories; $1.167 million is available in contract funding to local Level A Public Health Laboratories for training and surge capacity; $552,000 is available in contract funding for two additional Level B laboratories, approved by CDC; $460,000 is available to contract for enhanced laboratory connectivity; $230,001 is available in contract funds for continue Level B laboratory support from the existing CDC cooperative agreement; and $85,000 is available for a contract to support border health training needs in Imperial County.

Focus Area E: Health Alert Network/Communications and Information Technology

This CDC Focus Area requires state and local public health agencies to establish and maintain a network that will support the exchange of key information and training over the Internet by linking public health and private partners on a 24/7 basis, including rapid dissemination of public health advisories. It also requires that the network ensure secure electronic data exchange between public health partners' computer systems and to ensure the protection of data, information, and systems with adequate back-up, organizational, and surge capacity to respond to bioterrorism and other public health threats and emergencies. A total of $7.6 million is requested for these activities and to cover the costs of four limited-term staff.

- Obtain approval for RHEACTS (the State's health alert network) from internal State control agencies.
- Develop contracts to fully develop and maintain RHEACTS during its four implementation phases, including assessment of connectivity capability, availability of redundant systems and RHEACTS ability to interface with other emergency and local emergency response partners, security and protection of data, integration with other systems (RIMS, REDDINET, NEDSS) and site preparation.
- Prepare an implementation plan for increased functionality (e.g., distance learning platform to support video streaming, web-casting, and video conferencing, expanded teleconferencing), a fail-over system and increased interfaces with local redundant communication systems, security policies and procedures.
- Develop and test directories of clinical personnel and public health practitioners that will have access to RHEACTS.
- Provide technical assistance and consultation to local health jurisdictions.
- Plan and conduct training for RHEACTS state and local users.
- Purchase additional servers and licenses.

Of the $7.6 million available in Focus Area E, nearly $4.4 million is available to local health jurisdictions to participate with CDHS RHEACTS planners to ensure that 90 percent of their populations are covered by the health alert network, to develop a local communication system that provided for a 24/7 flow of information among state-local public health officials, hospital emergency rooms, public health laboratories, and law enforcement, including assessing and inventorying local communications connectivity capability. An additional $1.24 million will be spent by CDHS on purchasing licenses for local health jurisdictions.

Focus Area F: Communicating Health Risks and Health Information Dissemination

This CDC Focus Area requires that the State and local public health agencies and organizations to develop an effective risk communications capacity that provides for timely information dissemination to citizens during a bioterrorist attack, an infectious disease outbreak, or other public health emergency. Such capacity at the state and local level must include training for key individuals in communications skills, the identification of key individuals who can communicate to the public and policy makers about infectious diseases, preparation of printed materials, timely reporting of critical information, and effective interaction with the media. To conduct these activities, of the $3.0 million available CDHS requested $821,278 -- a portion of which will cover the cost of three staff. To develop a single risk communication system, a two-phased approach was proposed:

- Phase I: Planning the Health Risk Communication System (Months 1-8). During that time, staff would be hired, stakeholder groups identified and working groups convened, a needs assessment tool that examines the needs of information providers, the public health workforce and the public will be developed and implemented, work with the Office of Binational Border Health on specialized risk communication will be initiated, communication protocols to assure timely release of information will be reviewed and finalized, and resources provided to local health jurisdictions to assist them in completing their local needs assessments and in conducting initial activities. A portion of Phase I assessment activities will be to identify tribal, regional, inter-state, border, or workplace specific issues that the health risk communication system should address.
- Phase II: Developing and Pilot Testing the Health Risk Communication System (Months 6-18). During this phase, a comprehensive health risk communication strategy will be developed, a communications and media training program will be piloted a the local/regional level, a media guidance toolbox kit will be piloted, written, visual, and oral communication alert materials for selected bioterrorism agents will be field tested, a formative evaluation of the training program, kit, and communications materials will be completed, health communication coordination and clearinghouse gaps/needs will be identified, case scenario drill with sample agencies and stakeholders will be conducted, and effective risk communication products will be disseminated statewide.

Of the $3.0 million available in this Focus Area, about $2.2 million will be made available to local health jurisdictions to assist with the completion of needs assessment activities to identify local gaps, participate in planning activities with CDHS, to evaluate training and communications materials and draft protocols for the coordinated state-local health risk communication system, to participate in case scenario drills, and for local infrastructure development.

Focus Area G: Education and Training

The CDC Focus Area requires that State and local health agencies have the capacity to assess the training needs of key public health professionals, infectious disease specialists, emergency department personnel, and other healthcare providers related to preparedness for and response to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies. A second step would be to plan for effective education and training to key audiences through multiple channels. Of the $6.0 million available in this Focus Area, CDHS requested $1.78 million to cover the costs of six limited-term staff, contracts, and other activities.

- Review existing needs assessments, tools, training models, adult learning literature, and existing state/local training.

- Convene a state-local working group to advise on needs assessment methodologies and to work on an integrated assessment with CDC/the Centers for Public Health Preparedness.
- Work with local partners to integrate and coordinate disparate training resources into unified training system, where possible, including contracts and memoranda of understanding with existing information providers, if appropriate.
- Based on the needs assessment, develop a model core curriculum for a standardized training program.
- Offer training through satellite-based courses, Internet-based (e.g., RHEACTS) systems, audio-conferencing, and in-person training that counties can link to.
- Through a distance learning coordinator, coordinate CDC training and those offered by counties that other counties can link to.
- Provide specialized training for CDHS epidemiologists, develop a clinical outreach/educational program for clinicians, and hire microbiologist laboratory trainer to work directly with the National Laboratory Training Network.

Of the $6.0 million available in Focus Area G, $4.2 million is available to local health jurisdictions to provide resources to assess local training needs, developing an ongoing training plan, to work with CDHS on training program content and curricula, and to develop the capacity to facilitate/provide education and training sessions on bioterrorism, infectious disease outbreaks, and public health emergencies through a trained distance learning coordinator, access to distance learning, or Internet-based learning.

HRSA Hospital Preparedness Program

The Hospital Preparedness Program, administered by HRSA, will issue new cooperative agreement awards to State and Territorial health departments and selected municipal governments. The funding -- $9.96 million in California, with an additional $3.65 million for Los Angeles -- is being issued in two phases, with a 24 month budget period from February 25, 2002 through February 25, 2004.

Purpose: The purpose of this cooperative agreement program is to foster the preparedness of the nation's hospitals and health care system to respond to bioterrorist events. This will allow the health care system to become more prepared to deal with nonterrorist epidemics, as well as outbreaks of rare diseases. A prime focus area will be the implementation of bioterrorism preparedness plans and protocols for hospitals. Development of statewide models for such protocols is encouraged, as is collaboration with other states and national organizations with expertise in this subject.

Implementation Requirements:
Phase 1 (Assessment and Approach): This phase required that CDHS mobilize a state/territorial/regional level effort to involve appropriate entities in preparation of two outcomes: (1) a needs assessment of preparedness and (2) an implementation plan. Twenty percent of the total award ($1.99 million) is available for development of an implementation plan. Phase I requires the development of an extensive advisory committee to assist in the development of implementation recommendations. CDHS completed the application requirements for this Phase on February 28, 2002. The application described CDHS' approach and identified the groups who would be represented on the advisory committee.
Phase 2 (Implementation): Release of the remaining funds , $7.97 million for CDHS, (an additional $2,927,338 for Los Angeles County) is dependent upon HHS' approval of the state's work plan, submitted April 15, 2002. Phase II outcomes: (1) improvements in hospitals and

other health care entities abilities to respond to biological events, and (2) development of a response system -- either a multi-tiered system in which local health care entities are prepared to triage, treat, stabilize and refer multiple casualties of a bioterrorist event to identified centers of excellence, or a multi-state or regional consortia to pool limited funding to accomplish these goals. Grantees will be required to allocate at least 80 percent of the Phase 2 funds to hospitals through written contractual agreements. To the extent justified, a portion of these funds could be made available to collaborating entities that improve hospital preparedness.

CDHS' Approach and Work Plan: CDHS entered into an interagency agreement with the Emergency Medical Services Authority (EMSA) for EMSA to take the lead on Phase I and Phase II. Approximately $1.0 million of the initial Phase I funding was budgeted for staff and consultants at EMSA to conduct planning activities. The remaining $1.0 million was set aside pending recommendations from an advisory committee for hospital-based implementation activities. For Phases I and II, EMSA has proposed hiring 4 staff, a Medical Consultant/Director and a Planning/Needs Assessment Consultant(s). In conjunction with the advisory group, the Hospital Bioterrorism Preparedness Planning Committee (HBPPC), EMSA will:

- Review all current hospital needs assessment activities in California (hospital-by-hospital or systemwide), information from JCAHO hazard vulnerability assessments.
- Create a database that includes hospitals, outpatient facilities, EMS systems, poison control centers to house the needs assessment information.
- Contract with a consultant/consultant group to develop, conduct, and analyze the statewide hospital bioterrorism needs assessment. This assessment will focus on general acute care hospitals. This assessment must meet an extensive set of criteria recommended by HRSA grant provisions and will be completed by October 2002.
- Based on the needs assessment, identify the need for statewide hospital communication linkages, technical assistance needs of hospitals, and capacity gaps across a range of areas (e.g., capability for triage, isolation, quarantine, treatment, ability to license/credential extra personnel or manage unsolicited clinical help, hospital training needs, utility of existing hospital protocols, needs of special populations).
- Funding decisions concerning the initial Phase I distribution of monies to hospitals will be made by the HBPPC in May 2002.
- The implementation plan will be finalized by February 2003 and contracts for allocations to hospitals will be completed by June 2003 (allocations distributed July 2003).

Metropolitan Medical Response System Initiative

The Office of Emergency Preparedness within the U.S. Department of Health and Human Services developed the MMRS initiative to foster a coordinated (fire, police, emergency management, public health, etc.) response to incidents involving weapons of mass destruction. Twenty-five cities nationwide were funded in 1997, with 45 added in the next two years. In California, the original cities (San Jose, Los Angeles, San Diego and San Francisco) received funds beginning in 1998, and 10 additional California cities received funding as of 2001. This new allocation will provide $400,000 to four new California cities and an additional $200,000 to three California cities that received partial funding in Fiscal Year 2001, for a total of 18 California cities with MMRS funds. These funds are not distributed through the state health agency, but are provided directly to the mayors of the designated cities.

Attachment A: Critical Benchmarks for Bioterrorism Preparedness Planning

1. Designate:
   - A Senior Public Health Official within the State/local health department, to serve as Executive Director of the State Bioterrorism Preparedness and Response Program.

CDC Deliverable

   - A Coordinator for Bioterrorism Hospital Preparedness Planning.

HRSA Deliverable

2. Establish an advisory committee to include representatives from:
   - State and local health departments and government;
   - Emergency Management Agencies;
   - Emergency Medical Services;
   - Office of Rural Health;
   - Police, fire department/emergency rescue workers and occupational health workers;
   - Other health care providers, including university, academic medical and public health;
   - Community health centers;
   - Red Cross and other voluntary organizations; and
   - The hospital community (to include Veterans Affairs and military hospitals).

CDC Deliverable

3. Prepare a time line for assessment of emergency preparedness and response capabilities related to bioterrorism, other outbreaks of infectious disease and other public health emergencies to facilitate planning and setting implementation priorities.

CDC Deliverable

4. Prepare a time line for assessment of statutes, regulation, and ordinances within the state that provide for credentialing, licensure, and delegation of authority for executing measures, as well as special provisions for the liability of healthcare personnel, in coordination with adjacent states.

CDC Deliverable

5. Prepare a time line for the development of a statewide plan for preparedness for and response to a bioterrorist event, infectious disease outbreak, or other public health emergency.

CDC Deliverable

6. Prepare a time line for the development of regional plans for responding to incidents of bioterrorism, infectious disease outbreaks, and other public health threats/emergencies.

CDC Deliverable

7. Develop an interim plan to receive and manage items from the National Pharmaceutical Stockpile and other sources, including mass distribution of antibiotics, vaccines, and

medical materiel. Within this interim plan, identify personnel to be trained for these functions.

CDC Deliverable

8. Prepare a timeline for developing a system to receive and evaluate urgent disease reports from all parts of the state and local public health jurisdiction on a 24 hour a day, 7 days a week basis.

CDC Deliverable

9. Assess current epidemiological capacity and prepare a time line for achieving the goal of providing at least one epidemiologist for each Metropolitan Statistical Area (MSA) within the state having a population greater than 500,000.

CDC Deliverable

10. Prepare a time line for ensuring effective working relationships and communication between Level A (clinical) laboratories and higher level laboratories (i.e., Level B and C laboratories).

CDC Deliverable

11. Prepare a time line for a plan that ensures that the Health Alert Network covers 90 percent of the population.

CDC Deliverable

12. Prepare a time line for development of a communications system that provides for a 24/7 flow of critical health information between hospital emergency departments, State and local health officials, and law enforcement.

CDC Deliverable

13. Develop an interim plan to enhance risk communication and information dissemination to educate the public regarding exposure risks and effective public response.

CDC Deliverable

14. Prepare a time line to assess training needs - with special emphasis on emergency department personnel, infectious disease specialists, public health staff, and other health care providers.

CDC Deliverable

15. Establish a hospital bio-preparedness planning committee to assist the health department in its hospital preparedness activities. The advisory group must include the following entities:
    - State, territorial or municipal health department
    - State emergency medical services office
    - State emergency management agency
    - State hospital association
    - State office of rural health
    - State or regional primary care associations
    - Veterans Affairs and military hospital (if available)

HRSA Deliverable

16. Develop a plan/time line for implementation of state/regional hospital plans that could accommodate in an emergency at least 500 patients. HRSA Deliverable

Attachment B: Funding Summary

Grant	State Funding	Local Health Dept. Funding And Benefit*	Hospital and Health Care Providers Funding	Total Funding	Proposed State Positions for DHS & EMSA
CDC	$18,884,579	$41,931,666		$60,816,245	71.0
HRSA	$1,444,000		$9,818,000	$9,963,000	4.0
Total	$20,328,579	$41,931,666	$9,818,000	$70,779,245	75.0

- **Includes all categories A - C below**

A. Local Health Department (from Focus Areas A, B,E, F, G) $ 35,948,665**

Focus Area A:	$16,622,000
Focus Area B:	$ 8,500,024
Focus Area E:	$ 4,398,714
Focus Area F:	$ 2,219,534
Focus Area G:	$ 4,208,393
Total	$35,948,665

** These monies will be combined and distributed to local health jurisdictions using an allocation formula that takes into account population and core needs

B. Focus Area C - Local Benefit funding 4,739,001***

Local Health Dept. Level A Laboratory Training	$1,167,000
Contract to support Border Health Training (Imperial County)	$ 85,000
Contract to Expand Level B Support	$2,245,000
Continuing Level B Support	$ 230,001
Contract Funding for two additional Level B labs	$ 552,000
Connecting participating local labs	$ 460,000

C. Focus Area E – Local Benefit Funding $ 1,244,000***

Software Licenses for RHEACTS users & Training of local staff

*** These funds will be distributed as separate contracts to local public health entities or as direct purchases by CDHS on behalf of local health jurisdictions.

Total Local Benefit and Direct Funding **$ 41,931,666**

Attachment C: California's Response System

The Standardized Emergency Management System

The Standardized Emergency Management System (SEMS) was enacted by the Emergency Services Act (Government Code, Chapter 7, Title 2, Section 8607) in 1993, requiring the use of SEMS as a framework for responding to and managing emergencies and disasters involving multiple jurisdictions or multiple agencies. All state agencies with designated emergency response management roles as defined in the State Emergency Plan are required to utilize SEMS. The following systems are the framework of SEMS:

1. The Incident Command Systems adapted by the FIrefighting RESources of California Organized for Potential Emergencies (FIRESCOPE).
2. The multi-agency coordination system developed by FIRESCOPE.
3. Mutual aid agreements established such as those used in law enforcement, fire service and coroner's operations.
4. Defining an "operational area" to consist of a county and all political subdivisions within the county area.

SEMS is utilized by emergency managers and responders across California and has improved the organized response in the field and in local, operational area, regional and State emergency operations centers. After the September 11, 2002 terrorist attacks, the State of California activated local, regional and state emergency operations centers (EOC) on heightened alert status, and through the use of SEMS, the emergency management network was established when the response and follow up to potential anthrax exposures began to challenge the emergency response system.

California's Terrorism Response Plan

The California Terrorism Response Plan (CTRP) is an annex to the State Emergency Plan and was developed in 1999. The CTRP is a plan that forms a basis for all agencies to develop procedures for responding to a wide range of potential or actual terrorist incidents.

The CTRP established two critical committees: The State Strategic Committee on Terrorism (SSCOT) and the State Threat Assessment Committee (S-TAC). SSCOT was established to monitor terrorist trends and activities, determine the potential impact and related damage of validated terrorist threats, plan for the coordinated and comprehensive emergency response to such events and to provide timely guidance to SEMS organizations for agencies responding to specific threats or events. The S-TAC is to provide an an-going capability for rapid, "real time" assessment of information regarding the potential impacts from specific terrorist's threats or events in California. These two committees bring key local, State and Federal agency responders together for planning and threat assessment, resulting in a coordinated and organized state planning and response to any bioterrorism or terrorism incident.

Medical Mutual Aid and Collaboration in California

California's Master Mutual Aid Agreement (MMAA) was made and entered into by and between the State, its various departments and agencies, and the various political subdivisions (all 58 counties and the majority of California's cities) to facilitate implementation of the provisions of the Emergency Services Act. This agreement facilitates the rendering of aid to areas stricken by an emergency.
The State of California is divided into six (6) mutual aid regions for a more effective application, administration and coordination of mutual aid and other emergency-related activities. Within each of those regions, a Regional Disaster Medical and Health Coordinator (RDMHC), a volunteer position, is appointed by EMSA and CDHS. The role of the RDMHC is to oversee the development of plans for provision of medical or public health mutual aid among the counties in a region; and as a medical and health representative of a region unaffected by the emergency, to coordinate the acquisition of requested mutual aid resources from the jurisdictions within the region for the affected region.

Within each region there is also a Regional Disaster Medical and Health Specialist (RDMHS). The RDMHS is a full-time staffed position, paid by EMSA, who assists the State and RDMHC in development of regional plans for the provision of medical and health mutual aid resources. The RDMHS also coordinates intra-regional medical and health mutual aid in the event of a disaster within the region.

Each operational area designates a Medical and Health Operational Area Coordinator (MHOAC) who acts as the conduit for requesting and providing resources to and from other jurisdictions through the Regional Disaster Medical/Health Coordinator during an emergency. The MHOAC is usually the local Public Health Officer or Administrator, or the EMS Agency Administrator.

The State level management of medical mutual aid and response to disasters is a unique collaboration between EMSA and CDHS. When a disaster is declared and state response is anticipated or required, the Joint Emergency Operations Center (JEOC) is activated by EMSA and CDHS. Following the mandates of SEMS, EMSA and CDHS activate the JEOC for the organization and coordination of the State's medical and health planning, management and mutual aid. The JEOC coordinates directly with the Governor's Office of Emergency Services (OES), which is the oversight agency for the State management of disasters.

As was the case in most states in the nation, California was in the early processes of developing plans and protocols for biological terrorism. Until October 2001, the focus of emergency planners was primarily on chemical terrorism, with the exception of the CDHS efforts focused specifically on bioterrorism through the five-year CDC Bioterrorism Cooperative Agreement, issued in 1999. That focus quickly shifted in fall of 2002 for all emergency managers to planning for and management of biological terrorism events and other outbreaks of infectious diseases.

Current Emergency Planning Efforts

The planning for bioterrorism incidents requires collaboration and coordination across the healthcare system, including public health, rural health, public safety/EMS and emergency management agencies. This planning should include local, regional and State providers and responders.

California Health and Human Services Agency Disaster Coordinating Council

The California Health and Human Services Agency (CHHSA) has oversight of the majority of departments that provide state planning, preparedness and response for the services to victims of disasters within the State. In February 2002, the Disaster Coordinating Council (DCC) was established with representatives from all departments within CHHSA that prepares and plans for, and/or responds to emergencies/disasters within California. The DCC will ensure that the CHHSA and its departments are prepared to respond effectively to disasters and to define protocols, procedures and other activities that will ensure effective coordination between CHHSA departments.

State Strategic Committee on Terrorism

The SSCOT, chaired by the Governor's Office of Emergency Services, developed working groups within the committee to focus on high priority areas. One of the planning and preparedness sub-committees formed is the Medical and Health Working Group that focuses on bioterrorism preparedness and planning. EMSA and CDHS are the lead agencies for this working group. Another is the Subcommittee on the Protection of Public Health, co-chaired by CDHS and the University of California. A working group of this subcommittee is proposed as the advisory group for the CDC Bioterrorism Cooperative Agreement.

Hospital and Healthcare System Disaster Interest Group

The Hospital and Healthcare System Disaster Interest Group (DIG), a long-standing committee convened by EMSA and CDHS, is a public-private partnership of government agencies and hospital systems within California. The DIG has been very active in addressing hospital focused terrorism issues, producing emergency and disaster plans, protocols and policies for hospitals. This emergency planning group, "for hospitals – by hospitals", will continue the development of materials and will interact with the Hospital Bioterrorism Preparedness Planning Committee (HBPPC), proposed under the HRSA Cooperative Agreement, to collaborate on issues and products.

Local Public Health

Led by local public health efforts, Santa Clara County created a "Zebra Packet", Bioterrorism Information for Clinicians in November 2000. The "Zebra Packet" quickly became an important tool for public health clinicians, hospitals and clinics in recognizing a potential incident and proper reporting of a bioterrorism exposure to the local public health departments. Santa Clara County Public Health Department widely distributed the "Zebra Packet" (website: www.sccphd.org/diseasecontrol/bioterrorism.asp) and many counties developed a similar version for use in their public health and healthcare systems, including hospital emergency departments. Other educational programs include:

- January 2002, California chapter of the American College of Emergency Physicians (Cal-ACEP) Bioterrorism Task Force developed the "Biological and Chemical Terrorism Handbook".
- CDHS drafted the "California Hospital Bioterrorism Response Planning Guide" in October 2001. This comprehensive guidance provides hospitals with a template for planning, preparing and responding to bioterrorism. The draft guidance can be found at www.CDHS.ca.gov.

County and City Governments

Many counties and cities across California, such as San Francisco, Santa Clara, Los Angeles and San Diego, formed “Terrorism Early Warning” groups, consisting of local and regional experts who developed planning, preparedness and response protocols in responding to terrorism, including bioterrorism. The protocols, policies and recommendations from these groups will be utilized by the Hospital Bioterrorism Preparedness Planning Committee in development of the implementation plan and by CDHS. Several government agencies provide monies to cities for terrorism preparedness and response, including the Department of Defense, Department of Justice and the Department of Health and Human Services - Office of Emergency Preparedness programs. EMSA and CDHS have participated in the MMRS quarterly planning meetings. A State Advisory Committee will address the maintenance and sustainability of the MMRS programs for the future.

University of California, Los Angeles, Center for Public Health and Disasters

The UCLA Center for Public Health and Disasters was established in 1997 to address the critical issues faced when a disaster impacts a community. Based in the Department of Community Health Sciences of the School of Public Health, the Center facilitates dialogue between public health and medicine, engineering, physical and social sciences, and emergency management. Under CDHS' 1999 Cooperative Agreement with CDC, a contract was issued to the Center to develop a web-based curriculum for bioterrorism training for health care professionals. The course for emergency department and primary care physicians is available through the UCLA website and has been downloaded by more than 1,000 individuals since October 2001. The Center also developed a two-day seminary for public health officers and executives that were pre-tested by Santa Barbara County. Recently been named as a Center for Public Health Preparedness by CDC, the Center will have additional activities related to public health assessment and training in support of states receiving funds from CDC for bioterrorism.

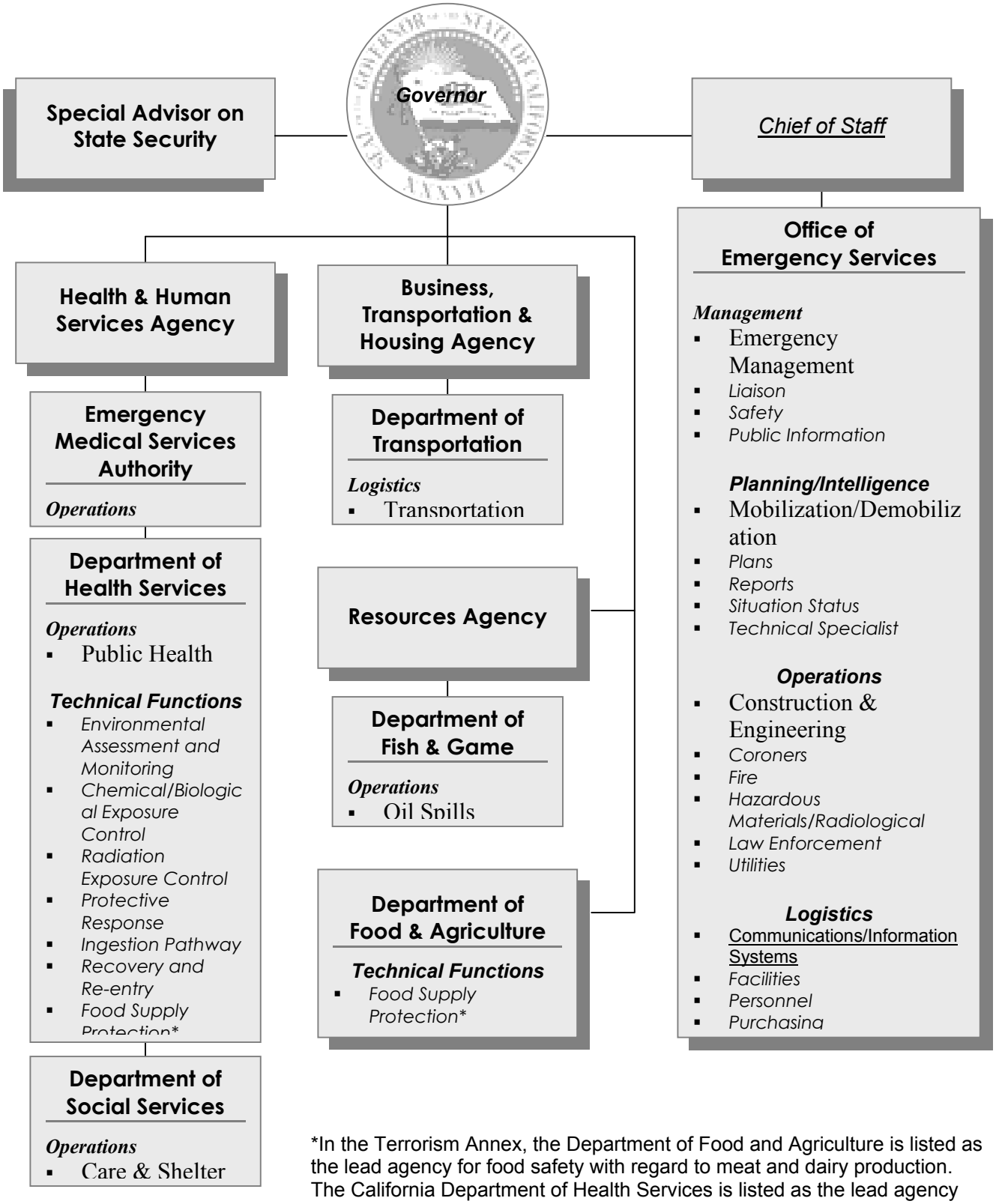
State Public Health

As the lead public health agency in California, CDHS has an important responsibility to prevent, mitigate, investigate, and respond to bioterrorist events, should they occur in our state. CDHS responds to incidents of bioterrorism through the Emergency Preparedness Office (EPO), but many other essential departmental resources from the laboratories, disease surveillance and epidemiology, environmental health, licensing and certification of health facilities, and health communications are also intimately involved. The EPO has formalized mission-critical partnerships with external agencies, including the Governor's Office of Emergency Services, the Emergency Medical Services Authority, and other state and local partners. CDHS has drafted response plans for bioterrorism surveillance/epidemiolgic activities and for health facilities.

Within CDHS, the Office of Binational Border Health responds to a range of cross-national health issues, including terrorism, and has formed a planning group to address bioterrorism. The California Border Environmental and Public Health Protection Fund to assist agencies in California and Baja California to address threats to the health or environmental quality of California residents. Additionally, the California section of the U.S. – Mexico Border Health Commission is also available to assist with mechanisms for binational resource sharing.

The following flow chart illustrates the relationship of the CDHS and EMSA with other State agencies during a potential or actual terrorism event, including bioterrorism.

Lead Agencies for Emergency Response
State Emergency Plan – Terrorism Annex



*In the Terrorism Annex, the Department of Food and Agriculture is listed as the lead agency for food safety with regard to meat and dairy production. The California Department of Health Services is listed as the lead agency for food safety with regard to food manufacturers and wholesalers. Both agencies share the lead for food safety with regard to crop production.